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ABSTRACT

Discrepancies are discussed which exist in establishing criteria for defining incest and for reporting accurate data on its incidence. Etiological issues of individual and familial pathological patterns are examined, as well as the short- and long-term consequences of incestuous events as they affect the victim and other family members. Treatment considerations for the incestuous family are reviewed. Inadequacies in documentation of techniques specifically relevant to the treatment of the family as a unit are discussed, as well as current issues centering around prevention. (Author/BMW)

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"Incest: No longer a family affair"

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During the past decade there has been a growing interest in the topic of incest. Most of the literature focuses on theoretical issues centering around integration or clarification of existing theories of human behavior as an explanation for incestuous behavior. A small, but ever expanding, portion of that literature is aimed at examining the developmental and environmental patterns of individuals and families who have experienced incestuous events, and has attempted to deal with the wider issues of prevention through diagnosis and post-event treatment considerations. It is to this latter concern that this paper is addressed.

Incest is often defined as sexual relations between individuals in a family who would by law be forbidden to marry. However, as anthropologists can explain, these laws vary from culture to culture; homologously, the incest taboo varies from culture to culture.

Statistics which attempt to reflect an accurate picture or patterning are grossly inaccurate either because data is just not available for documentation or when data is available it is inappropriately categorized. As Sagarin (1977) notes, most of the data concerning incest is compiled from court records of which "...there is a variety of offenses under which incest is listed and prosecuted." (pg. 134) Not only are we dealing with a skewed biased sample which does not in any way reflect the true nature or incidence of incest in the general population, but we are also dealing with the problem of a lack of agreement as to just what

constitutes a definition of incest. As Sagarin cites, cases are sometimes classified as "indecent offenses with children under age" in one place and "statutory rape" in another, with a failure to make any distinction between whether or not the offender is a blood relation. Sagarin suggests that such a distinction between "consanguine and affinal relations" would enable researchers not only to obtain a clearer understanding of the "....effectiveness of the incest taboo, its origin and its psychological internalization". (pg. 126) but also that "frequency etiology, and consequences may be found to differ when such distinction is made". (pg. 135) giving rise to more accurate descriptions of cause and effect paradigms which would enable us to more effectively deal with the issues of prevention and treatment. In addition to the need for more accurate and consistent definitions regarding social, moral, spiritual and legal terms describing the status of the relationship between the people involved, Rosenfeld (1977) also stresses the need for a clearer description of the nature of the acts committed.

The strength of the incest taboo is generally seen as most binding between mother-son, less binding between father-daughter, and least binding between brother-sister (Frances, 1976; Meiselman, 1978.)

The strength of the taboo as concerns homosexual incest, including documentation of individual traits and family dynamics, has never been posited (Awad, 1976). Father-son incest has been reported on (Awad, 1976; Langsley, et. al., 1968) but there is

no documentation of any incidents of mother-daughter, or same sex sibling involvements.

Frequency of occurrence within these groups is seen as occurring most often between father (stepfather)-daughter, less often between brother-sister and least often between mother-son (Awad, 1976; Herman and Hirschman, 1977; Browning and Boatman 1977). Nakashima and Zakus (1977) disagree with this frequency and cite Gebhard, et. al. (1965) who "...indicate that brother-sister incest occurs most often, probably five times as often as father-daughter incest", further stating that because of its transient nature and lack of negative effects it is not revealed.

The age level of the victim at the time the incestuous event occurs ranges, in the published literature, from age four through adolescence with the mean around puberty for father-daughter incest (Herman and Hirschman, 1977; Meiselman, 1978; and Browning and Boatman, 1977). Mother-son reports seem to indicate a mean age between adolescence and young adulthood, (Margolis, 1977). Sibling incest is less clearly defined according to developmental levels and seem to cover all ages including later adulthood, even though there is no mention made of incestuous events and the adult population in the literature.

Duration of the incestuous event over long periods of time is prominent in father-daughter incest according to Herman and Hirschman, (1977) and Browning and Boatman (1977) and is more or less sporadic in other forms of incest.

Incest is seen as being more traumatic for a female than a male (Pittman, 1977; Herman and Hirschman, 1977).

Pittman (1977) feels that homosexual incest carries the greatest potential for traumatic effects, greater than heterosexual incest since the individual is confronted and overwhelmed by the elements of a dual taboo. When incest is initiated in adolescence it is seen as carrying the most damaging effects, followed in severity by experiences at a pre-pubic age (Sloane and Karpinski, 1942; Gentry, 1978). In a study conducted by Meiselman (1978) the opposite was found to be true. Father-daughter incest is seen as carrying the greatest potential for damage in later life (Weeks, 1976; Herman and Hirschman, Meiselman, 1978) with sibling incest having the least long-range damage (Weeks, 1976), but as Pittman (1977) points out "Sibling incest becomes more problematic with age." (pg. 129).

Incest which is ongoing over a long period of time is more damaging, and resulting maladaptive behavior is less open to change than is single or intermittent but rare events, (Gentry 1978; Rosenfeld, 1979). Margolis (1977) and Nakashima (1977) feel that although mother-son incest is extremely rare it usually involves the most severely disturbed participants and the damage due to the experience may never be fully undone.

With such confusion concerning the issue, we cannot accurately know if the incidence of incest is increasing, decreasing or that we are coming to recognize a norm. If there is an upward trend, it is difficult to know whether the explanation for the increase in the number of reported cases experienced currently is indicative

of (1) a trend toward demystification of the incest taboo due to the changing role of the traditional family (Messer, 1969); (2) simply more people are freely talking about their incestuous behavior and feelings or, in fact, (3) is the direct result of a dysfunctional family system (Lustig, et. al., 1966; Browning and Boatman, 1977; Pittman 1977; Gutheil, 1977; Nakashima, 1977; Rosenfeld, 1977; Sholevar, 1975; Meiselman, 1978). This latter position carries with it the implication that not only the dysfunctional family sustem, but also the rising incidence of incest, is an anomaly, since the social conditions which precipitate them are indigenous to this time period.

Very clearly, there is a range of variability among professionals as to just what propels individuals to pursue or not pursue sexual relations inside a specified prohibited social context.

Most assuredly, the taboo which serves to inhibit overt sexuality between genetic members of a family unit of close proximity is not the same taboo which is in operation when genetic members have been separated for long durations; nor is it the same taboo which confronts non-genetic individuals who enter into natural genetic role situations (i.e. step-parents).

As Sagarin (1977) notes "....intimacy itself is one of the mechanisms for internalization of the taboo". (pg 130).

Meiselman (1978 pg. 111) lists a variety of personality and behavior profiles representative of incestuous family members. These range from various endogamic personality disorders through psychopathic character disorders, and psychotic and organic

conditions which describe the father. The mother (in the father-daughter dyad) is usually seen as coming from a background of emotional deprivation, either absent from or incapacitated in the family system, usually passive, dependent, somewhat masochistic, and usually suffering from depression and sexual dysfunction. The child is usually seen as placed in the role of the adult with adult responsibilities, usually attractive, and usually (as is the mother) having difficulty with separation/individuation issues.

Herman and Hirschman (1977) note that much of the information in the literature on incestuous families is drawn from lower socioeconomic groups where such characteristics are fairly common and that incest does not necessarily have a statistically greater chance of occurring in such dysfunction family settings, but rather believe that incest has just as great a chance of occurring in intact family systems of all socioeconomic levels. Meiselman (1978) states that such inadequacies in research lead "...people to believe that incest only occurs in an extremely lower-class society among very sick people". (pg. 332).

Pelton (1978) disagree with this position that problems of child abuse and neglect are broadly disturbed throughout society. His emphasis focuses on the quality of stress situations which confront lower socioeconomic groups indicating that such groups experience a greater number of stressful events; that the intensity and duration of such stressful events are greater in such groups, and that there are less resolving and satisfying alternatives which members of such groups may utilize to alleviate

stressful situations. Under such circumstances, levels of frustration are higher, and chances of behavioral displacement greater - behavior being directed toward the immediate environment, namely the family. Thus, while child abuse and neglect may occur in middle and upper socioeconomic families it occurs with less frequency, extended over a shorter period of time and usually has a lesser degree of trauma attached to it, than it does in lower socioeconomic families.

Just as the causes for incest are complex so it is the state of research concerning the issue of both short and long term consequences or effects of incest on either the victim or other family members in their role as participant or observer.

Not all researchers agree that incest need necessarily have negative consequences (Yorukoglu & Kemph, 1966; Lukianowicz, 1972; Pittman, 1977), although most will agree this may be more true for males than for females (Sloane & Karpinski, 1942; Pittman, 1977; Herman & Hirschman, 1977).

Many researchers feel that statistics which reflect a high correlation between incest and various negative effects; obtain their data from cases of maladaptive behavior severe enough to have reached the court system or come to the attention of social community agencies, or finally, are discovered or raised as a possible issue in a private therapeutic setting usually years after the real or fantasized event is reported to have occurred. Individuals who have not experienced negative effects are never filtered through a social system in order for statistics to be documented.

Rosenfeld (1977) believes that an individual's experiences of deprivation and rejection derived from the context of the disorganized family system have more long term effects than that of the sexual experience itself. Nakashima and Zakus (1977) agree "....incest in some situations may be only a minor theme in the pathological chaos of the multiproblem family."

Various studies which have attempted to examine the issue of consequences on the victim do show a trend in behavior that researchers considered to be exemplory of "negative consequences". On studies with lower-socioeconomic groups "consequences" appears to take the form of acting-out, behavior disorders and depression (Sloane & Karpinski, 1942; Janes, 1977; Lukianowicz, 1972) whereas with middle and upper socioeconomic groups "consequences" appears to take on neurotic features being expressed in terms of diffused anxiety, depression, sexual dysfunction and psychsomatic problems (Browning & Boatman, 1977; Bernstein and Tenbensel, 1977; Meiselman, 1978). This is not always so clearly defined and choice of symptom probably has more to do with personality and socio-cultural variables discussed by Herman and Hirschfield, 1977; Pelton, 1978; and Meiselman, 1978).

As Herman and Hirschman note in a study conducted in 1977, "The severity of their complaints seemed to be related to the degree of family disorganization and deprivation in their histories rather than to the incest history per se." (Pg. 472).

In describing multigenerational patterns of incest, Rosenfeld (1977) states that it has been "our observation that many of the

abusing parents had been sexually abused as children offers further evidence that incest may impair the child's ability to achieve an adult sexual and parenting relationship, and may perpetuate the patterns in subsequent generations". (pg. 334). Other researchers have also found this to be true (Nakashima and Zakus, 1977), and as Gentry (1978) succinctly states, "the abusing parent was an incest victim as a child." (pg. 363)

Interestingly enough it is not only the victim whose own experiences would lend to this perpetuation of the pattern. Ralphing, Carpenter and Davis (1967, cited Meiselman, 1978 pg. 87) describe the case of an incestuous father, who as a child, had witnessed the ongoing sexual relationship between his own father and his older sister concluding that this experience was a determining factor in his own incestuous behavior, which indicates that children need not necessarily experience a traumatic event directly to be affected by that event in a manner as if they had experienced it directly.

As Rosenfeld (1977) notes, the question of negative short and long term consequences due to incestuous events is presently unanswered.

Treatment Considerations

Selection of the most effective treatment intervention for the incest victim and other family members follows from a clear understanding of the antecedent variables which led up to the problem situation, of the dynamics of the family system and its individual members which sustains the problem situation, and of

the boundaries both spatially and temporally which define the problem situation.

Pittman (1977) discusses the importance of defining the problem of incestuous events and distinguishes between five parameters: (a) real or imagined; (b) overt or covert (among family system members); (c) permanent or temporary (in its effects on family functioning and member development); (d) unique or habitual (degree to which it is sustained by family members); (e) structural or incidental (is it part of the family pattern?).

There have been a variety of approaches suggested as possible treatment modalities for the incest victim and family members, including individual therapy, marital counseling, family therapy, sex therapy and conjoint family therapy - singularly or in combination (Nakashima and Zakus, 1977, Pittman, 1977; Gentry, 1978; Meiselman, 1978; Herman and Hirschman, 1977; Rosenfeld, 1977; Giaretto, 1976; Awad, 1976; Sholevar, 1975).

Wijesinghe (1977) recommends and Meiselman (1978) agrees that hypnotherapy with adults who have experienced incestuous events as children "...provides a means to integrate real and fantasized incestuous conflicts". which have come to be believed if they are not real; or distorted if they are real.

Although Conjoint Family Therapy is considered the most desirable (Rosenfeld, 1977; Herman and Hirschfield, 1977; Gentry, 1978) it is not always possible to implement - the reasons for which Meiselman (1978) notes has made many therapists disenchanted with family therapy. Many helping professionals feel that it is

not appropriate to discuss all family matters, sexual or otherwise, in the presence of children who might be further damaged by such discussion. Just how much information and degree of confrontation between victim and the offender would be appropriate for a 4, 5, or 6 year old as compared to an 11, 12, or 13 year old? To what degree should helping professionals use confrontation in the case of youth who at 12, 13 or 14 years of age shows behavioral signs believed to be associated with incest? What degree and kind of follow-up should there be on a young child ten years of age or under to be sure that the incest hasn't been distorted beyond actual occurrence? Furthermore, when should a family be involved in treatment, particularly when one or both parents may not be aware of the incest and who might be punitive if this is revealed to them? Some further reasons for disenchantment with family therapy have been indicated to be the unwillingness of the perpetrator, or other family members, to participate in therapy at all, or if they do, to get them to do so on a consistent basis. This unwillingness may be due on the part of the family to fear of punishment by legal authorities; fear, shame and guilt attached to exposing details of incestuous events; and their fear of dissoultion of the family or separation of some of its members. The issue of separation of either the victim or the offender is sparingly dealt with in the literature. Most will agree that the primary response of helping agents and agencies should be one of protection of the victim. (Meiselman, 1978; Gentry, 1978).

Gentry (1978) feels that the child's removal from the home should be considered only when the family members are not emotionally and psychologically equipped to restrain the behavior of the offender.

Pittman (1977) feels that separation should never be used as a substitute for treatment. If separation is necessary (as may be the case for the treatment of psychosis or alcoholism) the family members should be reunited as soon as possible.

While Meiselman (1978) feels that whatever position best guarantees the security of the child determines the therapeutic intervention. This can only be done by having a full understanding of the context in which the incestuous event(s) occurred.

Herman and Hirschman (1977) note that very little in the way of specific techniques is known about how to help the incest victim. Treatment techniques are primarily focused on the pathology of individual members of the dysfunctional family system, rather than with techniques for dealing with the dysfunctional family system itself.

Pittman (1971) describes the issue of denial which is an exceedingly important determining factor in the sustentation of incestuous family pathology. This denial takes the form of denial that anything is going on, and denial of responsibility for their contribution as being a causal agent, of being a sustaining agent, and of being a resolving agent.

Another side of the issue of denial, apart from denial within the family structure itself, is denial on the part of the helping agent or agency. Meiselman (1978 pg. 332) speaks about how our

intense horror of incest inhibits us from thinking and dealing with incestuous behavior in a rational and non-judgemental manner, sometimes to the detriment of the victim since many negative effects would not have had the opportunity to develop in a more accepting atmosphere.

Issues of denial exist not only in the family but also are present in the helping agent and/or agencies which deal with the incestuous family.

Browning and Boatman (1977) comment on the uncomfortable nature the subject presents to clinicians, which may be why many disclosures of incest go unheeded by professionals, or if acknowledged are viewed as fictitious, which Meiselman (1978) notes inhibits and again adds to the possibility of negative consequences which otherwise might not have arisen if promptly and supportively dealt with.

Another issue of importance is therapeutically dealing with the incestuous family is the issue of blame.

Many writers feel that the childs participation in the incestuous act is not always one of an "unwilling victim" (Gentry, 1978; Pittman, 1977).

Gentry (1978) discusses how in many instances, even though the child is usually ambivalent, they will respond positively to the advances of an adult. The younger the child the less ambivalence experienced since there is less opportunity for socialization which is needed to internalize societal values which would promote guilt.

Freud's notation that children are sexual from birth is well accepted (Kinsey, 1948; 1953), but as Paradis (1976) notes children may well be sexual but they are not incestuous in their sexuality, but are rather innocent in their sexuality. Seductiveness on the part of a child toward a parent which is often observed in victims, is viewed more as a learned response for the need of non-sexual affection (Gentry, 1978).

An important task of the therapist is to assure the child they were in no way responsible for the incestuous event. Also, such support and clarification should be given to the child by other family members, including the offender (Herman and Hirschman, 1977; Gentry, 1978; Meiselman, 1978).

It is generally accepted that blame should never be focused on any single family member, including the offender (Gentry, 1978; Pittman, 1977; Meiselman, 1978). This is difficult to do in family therapy where blame is a shared responsibility that all members of a system contribute to the dysfunction of the system. But as Meiselman (1978) notes although blame should not be fixed, responsibility should be assumed.

Prevention

Gentry (1978) notes that much of the therapeutic work in the area of sexual abuse of children and adolescents is focused on protection and secondary prevention instead of primary prevention and rehabilitation.

With the advent of family therapy over a decade ago, we have moved from examining the individual in isolation to examining the family in isolation. If the individual's relationships, that which is intrapsychic, is a reflection of family interactions, then family relationships, that which is intrafamilial, is a reflection of interactions between some even larger social unit. Such extrafamilial factors must be taken into consideration when dealing with dysfunctional family systems (Fleck, 1976; Hume, O'Connor and Lowery, 1977; O'Connor, 1977). As Meiselman (1978) notes "...prevention of incest is tied to improvement in the functioning of society as a whole..." (pg. 332).

Most of the literature centering on prevention deals with such issues as (a) education of the public; (b) changing societies attitudes toward the "victim" the "offender" and the "crime"; (c) more accurate follow-up by family physicians, teachers, helping agencies, religious advisors of "high risk families"; (d) making available community resources and support systems; (e) taking reports of incest, even if not indicated as reasl, as an indication of breakdown in family functioning (Gentry, 1978; Meiselman, 1978).

However, the published literature does not amply deal with sociocultural factors related to incest. For example, Clinicians should be made aware of the fact that the prevalence of incest is much greater in some subcultures and hence this behavior is less deviant from the norm. Therefore, the helping professional can understand that the behavior does not necessarily have the same stigma which it may have the population-at-large.

Giaretto (1976) notes that societal support systems for the incestuous family are to a large degree non-existent. He contends that when the offender is brought into the court or other community service system, there is a high risk that "...community intervention can be destructive of entire families already weakened by serious stress". He sees societies position on the incest victim and offender, as it exists today, as counter-productive and in need of serious revision.

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